l f		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155198	B. WING		08/02/2012
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				OWNSHIP LINE RD	
MARQUE	=IIE		INDIAN	NAPOLIS, IN 46260	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	on the Investigation of	F0000	The creation and submission	of
		or the Investigation of	10000	this plan of correction does no	
	Complaint IN00	)111505.		constitute an admission of any	
	G 1: Dio	)111505 G 1 1		conclusion set forth in the	
	_	0111505- Substantiated.		statement of deficiencies or a	ny
		ficiencies related to the		violation of regulations.	
	_	eited at F-282, F-333,			
	F-425 and F-51	4.			
	1	July 31 and August 1 & 2,			
	2012				
	Facility Number	r: 000105			
	Provider Number	er: 155198			
	AIM Number:	N/A			
	Survey Team				
	Diana Zgonc, R	N- TC			
	Connie Landma	ın, RN			
	Census Bed Typ	pe:			
	SNF:	85			
	Residential:	57			
	Total:	142			
	Census Payor T	ype:			
	Medicare:	33			
	Private:	109			
	Total:	142			
	Sample:	3			
	_				
	These deficienc	ies reflect state findings			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4QU411

000105

TITLE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155198	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/02/2012
NAME OF F	PROVIDER OR SUPPLIER	8140 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
			CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			ETED
		155198	A. BUII B. WIN			08/02/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1			
MADOLIE					OWNSHIP LINE RD		
MARQUE				INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services pro facility must be p in accordance wi plan of care.	QUALIFIED PERSONS/PER  vided or arranged by the provided by qualified persons ith each resident's written  review and interview, the	F02	82	- What corrective action(s) w	vill	09/01/2012
		ensure a resident received			be accomplished for those		
		eations as ordered by the			residents found to have been	1	
	*	•			affected by the deficient		
		f 3 residents reviewed for			practice? - No corrective action	on	
	medication order	rs (Resident 'B').			can be made at this time for		
	Findings include	:			Resident B, because this resid was discharged prior to the commencement of this survey. How other residents having t		
	The record for R	esident 'B' was reviewed			potential to be affected by the		
	on 7/31/12 at 12:	15 P.M.			same deficient practice will b		
					identified and what corrective	е	
	were not limited pulmonary disease breath, depression disease, osteoper reflux disease and Resident 'B' was on 5/15/12 at 18:  The physician's concluded, but were following medical albuterol-ipratropevery 4 hours, needs	pium nebulizer inhalation ext dose due at 8:30 p.m.			action(s) will be taken?  - All newly admitted reside have the potential to be affected by the alleged deficient practice.  - The contracted pharmach has confirmed their ability to provide medications 24 hours every day, and has a contract with another nationwide pharmacy to provide backup medications as needed. The contracted pharmacy will delive medications within four hours or receipt of physician's orders.  - If unpreventable events hinder deliver of medications administration per physicians' orders, the Emergency Drug K (EDK) will be utilized in	ents ed e. y	
		eterol (advair) 500-50 a day, next dose due at			accordance to regulation. Otherwise, the physician will be	e	
	innananon, twice	a day, nort dose due at			contacted to request an order		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITT	A. BUILDING 00 COMPLI		
		155198				08/02/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	
MARCHE					OWNSHIP LINE RD	
MARQUETTE			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	9:00 p.m.				hold, to delay, or to use an	
	•	ngulair 10 milligrams			alternative course of treatmen	t.
					- What measures will be put	t
	1 2 2 2	ry evening, next dose due			into place or what systemic	
	at 9:00 p.m.				changes will be made to	
	rosuvastatin (Cro	estor 5 mg orally) once a			ensure that the deficient	
	day, next dose d	ue at 9:00 p.m.			practice does not recur? - A	ll e
	trazadone (150 r	ng orally) at bed time,			licensed nurses will be	
	next dose due at	•			re-educated as to the policy ar	nd
		g orally) twice a day,			procedure for obtaining	.:
		• • • • • • • • • • • • • • • • • • • •			medications or alternate direct	
	next dose due at	9:00 p.m.			as prescribed by the physician outlined above As part of	i, as
					job-specific orientation, newly	
	The medication	administration record on			hired nurses will be educated	as
	discharge from t	he hospital on 5/15/12			to the policy and procedure for	
	_	ident did receive her			obtaining medications or altern	
		tions prior to discharge			direction as prescribed by the	
	•				physician, as outlined above.	-
	but did not recei	ve any evening			How the corrective action(s)	
	medications.				will be monitored to ensure t	he
	The medication	administration record			deficient practice will not rec	eur,
	(MAR) for May	indicated the resident did			i.e., what quality assurance	
	not receive the e				program will be put into plac	e:
	medications on 5	· ·			- For two months, nursing	
	incurcations on .	0/13/12.			management will audit each n	
					admission for the timely delive	•
		iew with the 1st floor			of medications, administration	OT
	Unit Manager or	n 7/31/12 at 10:45 A.M.,			medications per physician's orders, and utilization of the E	DK
	she indicated "W	/e have a lot of evening			- Information gathered from the	
	admissions. We	have to get the orders			audits will be forwarded to the	
		e physician and then we			Quality Assurance Committee	
		the pharmacy for a STAT			determine a future auditing	
		•			schedule.	
	1 -	ive 4 hours to get the				
	meds here"					
	During an interv	iew with LPN #1 on				
	7/31/12 at 3:00 I	P.M., she indicated				
		blems with the pharmacy,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

If continuation sheet Page 4 of 17

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155198	A. BUILDING B. WING	00	COMPLETED 08/02/2012
NAME OF I	PROVIDER OR SUPPLIER	8140 TC	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the administrator finally had to call the physician directly. The resident was very upset about her medications."  3.1-35(g)(2)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

If continuation sheet Page 5 of 17

i ´		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155198	B. WING		08/02/2012
NAME OF I	PROVIDER OR SUPPLIE	R	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
TVI IVIL OF I	NO VIDER OR SOLVEIL			OWNSHIP LINE RD	
MARQUI	ETTE		INDIAN	IAPOLIS, IN 46260	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0333 SS=D	483.25(m)(2) RESIDENTS FEERORS The facility must free of any signing Based on record facility failed to the ordered med the first 4 days a residents review (Resident 'B'). The additional stress nursing staff.  Findings included The record for Foon 7/31/12 at 12  Diagnosis for Rewere not limited pulmonary disease breath, depression disease, osteope reflux disease are Resident 'B' was on 5/15/12 at 18  The hospital distance for montelukast	REE OF SIGNIFICANT MED  It ensure that residents are ficant medication errors.  I review and interview, the ensure a resident received lication, Singulair, during after admission for 1 of 3 red for medication orders.  This caused the resident and distrust of the	F0333	- What corrective action(s) verice be accomplished for those residents found to have been affected by the deficient practice? - No corrective action can be made at this time for Resident B, because this survey Nurses involved in the medical errors detailed in this alleged deficiency have been educated disciplined per policy How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All newly admitted residents have potential to be affected by the alleged deficient practice An new admission orders will transcribed by a licensed nurse A second licensed nurse will check completed entries for accuracy of transcription. Both nurses will sign the admission medication administration reconstruction administration reconstruction and the deficient practice does not recur? - Allicensed nurses will be re-educated as to the process	vill 09/01/2012  n on dent tion d or e pe e e the ull e. th
	Review of the pl	hysician's orders provided		checking admission orders,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI 111	BUILDING 00		COMPL	ETED
		155198	A. BUII B. WIN			08/02/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
MARQUETTE				APOLIS, IN 46260			
			INDIAN	APOLIS, IN 40200			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to the pharmacy	and verified by LPN #1			including signing to confirm		
	indicated the Sin	gulair was not included			transcription accuracy on the		
	in the list of requ	iested medications.			admission medication administration record as outlin	od	
	1				above As part of job-specific		
	Review of the M	ledication Administration			orientation, newly hired nurses		
					will be educated as to process		
		For May indicated the			checking admission orders,		
		receive the Singulair on			including signing to confirm		
	5/15, 5/16, 5/17	or 5/18/12.			transcription accuracy on the		
					admission medication		
	A telephone orde	er, dated 5/18/12,			administration record as outlin above <b>How the corrective</b>	ea	
	indicated the Sin	gulair was not requested			action(s) will be monitored to		
	with the original	admission medications.			ensure the deficient practice		
					will not recur, i.e., what quali		
	A social service	note, dated 5/17/12 at			assurance program will be p	-	
		cated " the resident was			into place: - For two months,		
	· ·				nursing management will audi	t	
		about medication			each new admission for the		
	incidents of the f	first night here"			completion of the double		
					checking of admission orders.		
	A nursing note, of	dated 5/18/12 at 9:13			Information gathered from the		
	P.M., indicated t	he resident complained			audits will be forwarded to the Quality Assurance Committee	to	
	she was not getti	ng her Singulair.			determine a future auditing	io .	
		the Singulair had been			schedule.		
	_	dmission orders to the					
		diffission orders to the					
	pharmacy.						
		1.15/00/10					
		note, dated 5/22/12 at					
	· ·	ated " the resident was					
	very angry that s	she had not been given her					
	medications at th	ne appropriate times and					
	she was keeping						
	dispensed."						
	A social sorvice	note, dated 5/22/12 at					
	2:42 P.M., indica	ated " the resident feels					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155198	A. BUILDING  B. WING	00	COMPLETED 08/02/2012
NAME OF I	PROVIDER OR SUPPLIER	8140 TO	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	additional stress due to worry about her medication and having to keep a log. Resident was assured she did not have to continue to log medications but indicated the resident would because of distrust."  An activity note, dated 5/22/12 at 3:03 P.M., indicated the resident was somewhat agitated " not happy about her medications."  During an interview with the Director of Nursing on 8/1/12 at 10:45 A.M., she indicated they were tracking medication errors on the "Medication Dispensing Events" form (form provided) and Resident 'B' had not been receiving her Singulair and it had not been ordered from the pharmacy on admission.  3.1-25(b)(9) 3.1-48(c)(2)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4QU411

Facility ID: 000105

If continuation sheet Page 8 of 17

	î ´					(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155198	B. WIN	_		08/02/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  DWNSHIP LINE RD		
MARQUE	ETTE				APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
F0425 SS=D	PROCEDURES, The facility must emergency druggeresidents, or obtate agreement descripart. The facility personnel to administering by the accurate acquand administering biologicals) to more resident.  The facility must personnel to administering biologicals to more resident.  The facility must personnel to accurate acquand administering biologicals to more resident.  The facility must services of a lice provides consultantly provision of phare Based on record facility failed to resident received medications from timely manner, from timely manner, from the resident were ensure they followed for medication entreviewed for medication entreviewed for medication entreviewed for medication entreviewed for medications includes A current facility.	provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed ninister drugs if State law under the general licensed nurse.  ovide pharmaceutical ng procedures that assure uiring, receiving, dispensing, g of all drugs and eet the needs of each  employ or obtain the ensed pharmacist who ation on all aspects of the enacy services in the facility. review and interview, the ensure a newly admitted a their ordered in the pharmacy in a sailed to ensure that only orded and prescribed for equilized and failed to wed the facility policy errors for 1 of 3 residents dications. (Resident B)	F04:	25	- What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? - No corrective action action be made at this time for Resident B, because this resident was discharged prior to the commencement of this survey. Nurses involved in the medical errors detailed in this alleged deficiency have been educated disciplined per policy How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All	on lent  tion d or e	09/01/2012
	and titled "Special	al Deliveries" and			action(s) will be taken? - All newly admitted residents have	the	

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Event ID: 4QU411

Facility ID: 000105

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	LAN OF CORRECTION IDENTIFICATION NUMBER:			00	COMPLETED
		155198	A. BUILDING		08/02/2012
		100100	B. WING		00/02/2012
NAME OF I	PROVIDER OR SUPPLIER	₹		CADDRESS, CITY, STATE, ZIP CODE	
				TOWNSHIP LINE RD	
MARQUI	MARQUETTE		INDIA	NAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	provided by the	Director of Nursing		potential to be affected by the	
	(DON) on 8/1/12	2 at 12:45 P.M.,		alleged deficient practice T	he
	indicated,	·		contracted pharmacy has	-J-
	1	edication orders received		confirmed their ability to provi	
	I			medications 24 hours every d and has a contract with anoth	-
	1 -	nd deemed necessary for		nationwide pharmacy to provi	
		efore the next scheduled		backup medications as neede	
	pharmacy delive	ry due to the urgent		The contracted pharmacy will	
	nature of the dru	g or the diagnosis of the		deliver medications within fou	
		eceived through a special		hours of receipt of physician's	
	delivery procedu			orders. A. If unpreventable ev	
		When a delivery is		hinder deliver of medications	
				administration per physicians	
	_	'STAT" as determined by		orders, the Emergency Drug I	Kit
	the circumstance	e and confirmed by the		(EDK) will be utilized in	
	pharmacist, it wi	ill arrive at the nursing		accordance to regulation.	
	facility with a fo	our-hour window."		Otherwise, the physician will I	
				contacted to request an order hold, to delay, or to use an	TO
	A aurrant undata	ed facility policy titled		alternative course of treatmer	nt
				B. All licensed nurses and QN	
	_	sion Checklist" and		will be re-educated as to the	
		Administrator on 8/1/12		medication administration pol	icv.
	at 10:25 A.M., ii	ndicated the nursing staff		C. All licensed nurses and QN	-
	must,			will be re-educated as to the	
	" verify admiss	sion orders with the MD."		facility policy for medication	
				errors What measures will	II
	A assumant sundata	d facility maliary titlad		be put into place or what	
		ed facility policy titled		systemic changes will be ma	ade
		Treatment incidents and		to ensure that the deficient	
	drug reactions" a	and provided by the		practice does not recur? - A	۸.
	Director of Nurs	ing (DON) on 7/31/12 at		All licensed nurses will be	
	1:20 P.M., indica	ated,		re-educated as to the process	
		feguard the resident. To		obtaining medications or alter direction as prescribed by the	
	_	and prevent future errors		physician, as outlined above.	
	identify causes a	ma prevent future errors		part of job-specific orientation	
				newly hired nurses will be	,
		An entry of the incident		educated as to the process for	r
	will be made in	the clinical record		obtaining medications or alter	
				direction as prescribed by the	

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Event ID: 4QU411

Facility ID: 000105

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00			ETED
		155198			08/0		2012
			B. WING		ADDRESS SITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					OWNSHIP LINE RD		
MARQUI	MARQUETTE			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	. –	DATE
	1.a. The record	for Resident 'B' was			physician, as outlined above.		
	reviewed on 7/3	1/12 at 12:15 P.M.			Licensed nurses or QMAs		
		1, 12 W 12.10 1			identified as failing to follow th		
	Diameter Con D	anidant IDI in aladad hart			policies will be re-educated ar		
	_	esident 'B' included but			or disciplined in accordance w		
		to chronic obstructive			facility policy B. All licensed		
	pulmonary disea	se, asthma, shortness of			nurses and QMAs will be re-educated as to the medicat	ion	
	breath, depression	on, coronary artery			administration policy. As part		
	disease, osteoper	nia, gastroesophageal			job-specific orientation, newly		
	-	d hypothyroidism.			hired nurses and QMAs will be		
	lonar arscase ar	a nypomyroranom.			educated as to the medication		
	Desident IDI	. 4			administration policy. License	ed	
		admitted to the facility			nurses or QMAs identified as		
	on 5/15/12 at 18	:38:42 (6:38 P.M.).			failing to follow these policies		
					be re-educated and/ or discipl		
	The physician's	orders on admission			in accordance with facility poli	cy.	
		re not limited to the			- C. All licensed nurses and	i -	
	following medic				QMAs will be re-educated as t		
					the facility policy for medication errors. As part of job-specific	TI .	
	•	pium nebulizer inhalation			orientation, newly hired nurses	2	
	1 -	ext dose due at 8:30 p.m.			and QMAs will be educated as		
	fluticasone-salm	eterol (advair) 500-50			the facility policy for medication		
	inhalation, twice	a day, next dose due at			errors. Licensed nurses or QI		
	9:00 p.m.				identified as failing to follow th	ese	
	^	ngulair 10 milligrams			policies will be re-educated ar	nd/	
		ry evening, next dose due			or disciplined in accordance w	vith	
	2 03/	ry evening, next dose due			facility policy How the		
	at 9:00 p.m.				corrective action(s) will be		
	,	estor 5 mg orally) once a			monitored to ensure the		
	day, next dose d	ue at 9:00 p.m.			deficient practice will not rec	ur,	
	trazadone (150 r	ng orally) at bed time,			i.e., what quality assurance		
	next dose due at	9:00 p.m.			program will be put into place	e:	
		g orally) twice a day,			- For two months, nursing	014/	
	next dose due at				management will audit each n admission for the timely delive		
	next dose due at	7.00 p.m.			of medications, administration	-	
					medications per physician's	J1	
	•	eial Delivery Request" for			orders, and utilization of the		
	medications was	faxed "STAT" to the			EDK. Any medication errors		
	bharmacy from t	the facility on 5/15/12 at			identified will be audited for		

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  MARQUETTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  c. Review of the MAR for May indicated the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.  During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician directly. The resident was very upset about her medications."  During an interview with the 1st floor	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE ( COMPL		
NAME OF PROVIDER OR SUPPLIER  MARQUETTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  c. Review of the MAR for May indicated the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.  During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the Administrator finally had to call the physician directly. The resident was very upset about her medications."	155198				08/02/	2012	
MARQUETTE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  C. Review of the MAR for May indicated the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.  During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician had not called us back. We had to make several phone calls and the Administrator finally had to call the physician directly. The resident was very upset about her medications."	NAME OF I	PROVIDER OR SUPPLIER		 	ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  C. Review of the MAR for May indicated the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.  During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the Administrator finally had to call the physician directly. The resident was very upset about her medications."							
the resident had received her Albuterol nebulizer treatment on 5/16/12 at 12 A.M. even though the medications were not received from pharmacy until 5/16/12 at 2:44 A.M.  During an interview with LPN #1 on 7/31/12 at 3:00 P.M., she indicated "there were problems with the pharmacy, they didn't have a medication and needed clarification of the physician's orders. It was late, there was a lot of havoc going on and the physician had not called us back. We had to make several phone calls and the Administrator finally had to call the physician directly. The resident was very upset about her medications."	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
Unit Manager (UM) on 8/1/12 at 3:20 P.M., she indicated she had called LPN #1 and LPN #2 and the nurses had told her LPN #2 had charted the Trazadone administered on 5/16/12 at 12:00 A.M., instead of on 5/15/12 at 12:00 A.M. and when LPN #1 came on shift she just charted above the previous nurses initials. The UM could not explain how LPN #2 could have given the Trazadone at 12:00 A.M., when the medications were not delivered until 5/16/12 at 2:44 A.M.		the resident had nebulizer treatmeeven though the received from ph 2:44 A.M.  During an interv 7/31/12 at 3:00 F were problems with didn't have a meclarification of the was late, there we on and the physician was very upset at the physician was very upse	received her Albuterol ent on 5/16/12 at 12 A.M. medications were not narmacy until 5/16/12 at 12 A.M. she indicated "there with the pharmacy, they dication and needed ne physician's orders. It has a lot of havoc going cian had not called us make several phone ministrator finally had to make sever				

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED							
155198		A. BUILDING B. WING	<del></del>	08/02/2012					
NAME OF F	AD CLUDED OD CLUDELIE			ADDRESS, CITY, STATE, ZIP CODE					
NAME OF PROVIDER OR SUPPLIER				8140 TOWNSHIP LINE RD					
MARQUE	ETTE		INDIAN	IAPOLIS, IN 46260					
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)				
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE				
1710	On 5/17/12, LPN	<u> </u>	1710		BATE				
		razadone at 9 and LPN #3							
	_	ne administered on							
	5/17/12 at 8.								
	_	interview the UM also							
		2 had indicated the							
		rol nebulizer treatment							
		d to her prior to the							
		very time because she had lse's medications by							
	mistake.	ise's inedications by							
	mistare.								
	3.1-25(a)								
	, ,								

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Event ID: 4QU411

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
and Plan of Correction liberitification number: 155198		A. BUILDING	00	08/02/2012			
		100100	B. WING				
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE  OWNSHIP LINE RD			
MARQUETTE				IAPOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	483.75(I)(1)						
F0514 SS=D	483.75(I)(1) RES RECORDS-CO SSIBLE The facility muse each resident in professional state complete; accuraccessible; and The clinical receinformation to ico of the resident's care and service preadmission so State; and programmed administration of the resident's care and service preadmission of the resident's care and service preadmission of the resident's care and programmed administration of the record facility failed to accurate document administration of the residents review administration.  Findings included the record for Formal of the	MPLETE/ACCURATE/ACCE  It maintain clinical records on accordance with accepted indards and practices that are rately documented; readily systematically organized.  In the must contain sufficient dentify the resident; a record assessments; the plan of es provided; the results of any creening conducted by the ress notes.  It review and interview, the ensure complete and entation of the medication ecord (MAR) for 1 of 3 and for medication (Resident 'B').	F0514	- What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? - No corrective action can made at this time for Resident because this resident was discharged prior to the commencement of this survey Nurses involved in the medication errors detailed in the alleged deficiency have been educated or disciplined per positive How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All newly admitted residents	DATE  09/01/2012  be B,  his licy.		
	Resident 'B' was admitted to the facility on 5/15/12.			have the potential to be affect by the alleged deficient practic All licensed nurses and QMAs be re-educated as to required	e.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
155198			B. WING 08/02/2012			08/02/2012	
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAIME OF PROVIDER OR SUPPLIER					OWNSHIP LINE RD		
MARQUE	ETTE			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG		5.112	
					documentation on the medicat	ion	
	The resident had	physician's order for			administration record per the		
	Trazadone 150 n	nilligrams by mouth at			medication administration police	<i>y</i> y.	
	bedtime and Albuterol Ipratropiom 2.5 mg nebulizer every 4 hours.				- What measures will be		
					put into place or what system	nic	
	The May MAR for Resident 'B' indicated the resident was given the medications on 5/16/12 at 9 by LPN #1 and on 5/16/12 at 12 A.M. by LPN #2 and on 5/17/12 at 9				changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					- All licensed nurses and		
					QMAs will be re-educated as to		
					required documentation on the medication administration reco	<b>I</b>	
by LPN #1 and at 8 by LPN #3. The May MAR for the Albuterol					per the medication administrat		
					policy. As part of job-specific	1011	
	nebulizer, dated 5/15/12 for 8 P.M., was blank and the resident received the				orientation, newly hired nurses	;	
					and QMAs will be educated as		
	nebulizer treatme	ent on 5/16/12 at 12 A.M.			required documentation on the		
					medication administration reco	-	
	During an interview with the 1st floor Unit Manager (UM) on 8/1/12 at 3:20 P.M., she called LPN #1 and LPN #2 and				per the medication administrat policy. Licensed nurses or QN	II	
					identified as failing to follow the	<b>I</b>	
					policies will be re-educated an		
		nurses had told her LPN			or disciplined in accordance w	ith	
					facility policy.		
	#2 had charted the Trazadone administered on 5/16/12 at 12:00 A.M., instead of on 5/15/12 at 12:00 A.M. and when L RN #1 some on shift she just				- How the corrective		
					action(s) will be monitored to	,	
					ensure the deficient practice		
when LPN #1 came on shift she just charted above the previous nurses initials. The UM could not explain how LPN #2 could have given the Trazadone at 12:00				will not recur, i.e., what quality	ty		
				assurance program will be pu	ut		
				into place:			
				- For two months, nursing			
	A.M., when the medications were not delivered until 5/16/12 at 2:44 A.M. On 5/17/12 LPN #1 charted administering				management will perform five random observations per week	c of	
					licensed nurses and QMAs for		
					proper medication administrati	<b>I</b>	
	Trazadone at 9 a	nd LPN #3 charted			and documentation per the		
	Trazadone admii	nistered on 5/17/12 at 8.			medication administration police	cy.	
					Thereafter, five random		
	3.1-50(a)(1)				observations per month of licensed nurses and QMAs for		
J.1 Jo(u)(1)							

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	COMPLETEI				
		155198	A. BUILDING  B. WING		08/02/201	2		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
MARQUETTE			8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)		
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PERCEDED E		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE CO	MPLETION DATE		
IAU	REGULATOR I OK	ESC IDENTITING INFORMATION)		proper medication administration per the medication administration per the medication administration per the medication administration per the medication errors identified will be audited for adherence to the medication policy and tracked on a medication error log.  Information gathered the audits will be forwarded Quality Assurance Committ determine a future auditing schedule.	ration olicy. n error from to the	DATE		

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